WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

# Arboviral Infection

**(Do not use this form for dengue fever or yellow fever)**

## PATIENT DEMOGRAPHICS

*NAME (last, first): _____
*ADDRESS (mailing): _____
*ADDRESS (physical): _____
*City/State/Zip: _____
*PHONE (home): _____ Phone (work/cell) : _____
*Alternate contact*: ☐Parent/Guardian ☐Spouse ☐Other
Name: _____ Phone: _____

*Birth date: __ / __ / ____ *Age: _____
*Sex: ☐Male ☐Female ☐Unk
*Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk
*Race: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐ Native HI/Other PI ☐Unk

## INVESTIGATION SUMMARY

**Local Health Department** (Jurisdiction): _____
**Investigation Start Date**: __ / __ / ____
**Earliest date reported to LHD**: __ / __ / ____
**Earliest date reported to DIDE**: __ / __ / ____

**Entered in WVEDSS?** ☐Yes ☐No ☐Unk
**Case Classification**:
☐ Confirmed ☐ Probable ☐ Suspect
☐ Not a case ☐ Unknown

## REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: ☐Laboratory ☐Hospital ☐HCP ☐Public Health Agency ☐Other
Reporter Name: _____ Reporter Phone: _____
Primary HCP Name: _____ Primary HCP Phone: _____

## CLINICAL

*Onset date: __ / __ / ____ Diagnosis date: __ / __ / ____ Recovery date: __ / __ / ____

*Arbovirus Reported (if not below, list: _____)
☐Eastern Equine **(EEE)** ☐La Crosse **(LAC)** ☐Powassan **(POW)**
☐Western Equine **(WEE)** ☐St. Louis **(SLE)** ☐West Nile **(WNV)**
☐Chikungunya (**CHK**)

### *Clinical Findings

| Y | N | U | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Fever (Highest measured temperature: _____ °F) |
| ☐ | ☐ | ☐ | Meningitis |
| ☐ | ☐ | ☐ | Encephalitis |
| ☐ | ☐ | ☐ | Myelitis |
| ☐ | ☐ | ☐ | Stupor |
| ☐ | ☐ | ☐ | Coma |
| ☐ | ☐ | ☐ | Paresis |
| ☐ | ☐ | ☐ | Acute flaccid paralysis |
| ☐ | ☐ | ☐ | Nerve palsies |
| ☐ | ☐ | ☐ | Abnormal reflexes |
| ☐ | ☐ | ☐ | Abnormal movements |
| ☐ | ☐ | ☐ | Convulsions |
| ☐ | ☐ | ☐ | Arthralgia |

### Clinical Risk Factors

| Y | N | U | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Underlying medical condition |
| ☐ | ☐ | ☐ | Immune suppression |

### Hospitalization

| Y | N | U | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Patient hospitalized for this illness |

If yes, hospital name: _____
Admit date: __ / __ / ____ Discharge date: __ / __ / ____

### Death

| Y | N | U | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Patient died due to this illness |

If yes, date of death: __ / __ / ____

## VACCINATION HISTORY

| Y | N | U | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Ever vaccinated for yellow fever (If yes, date: __ / __ / ____) |
| ☐ | ☐ | ☐ | Ever vaccinated for Japanese encephalitis (If yes, date: __ / __ / ____) |
| ☐ | ☐ | ☐ | Ever vaccinated for tickborne encephalitis (If yes, date: __ / __ / ____) |

## LABORATORY *(Please submit copies of all labs, including CSF studies associated with this illness to DIDE)*

| Y | N | U | |
|---|---|---|---|
| ☐ | ☐ | ☐ | *Elevated white blood cell count (>5 WBCs adjusting for RBCs by subtracting 1 WBC for every 500 RBCs) in CSF specimen |
| ☐ | ☐ | ☐ | * Elevated protein in CSF specimen |
| ☐ | ☐ | ☐ | *Isolation of specific arbovirus or demonstration of specific arbovirus antigen or nucleic acid |
| ☐ | ☐ | ☐ | *Four-fold or greater change in arbovirus-specific quantitative antibody titer in paired sera |
| ☐ | ☐ | ☐ | *Arbovirus-specific IgM antibodies in serum **with** virus-specific neutralizing antibodies in same or later specimen (PRNT) |
| ☐ | ☐ | ☐ | *Arbovirus-specific IgM antibodies in CSF **with** negative result for other IgM antibodies in CSF to other arboviruses |
| ☐ | ☐ | ☐ | *Arbovirus-specific IgM antibodies in serum or CSF **with no further testing** |

## INFECTION TIMELINE

*Instructions: Enter onset date in grey box. Count backward to determine probable exposure period*

| | Exposure period | | Onset date |
|---|---|---|---|
| *Days from onset* | _____ *(Enter Max Incubation)** | _____ *(Enter Min Incubation)** | |
| ***Calendar dates:*** | __ / __ / ____ | __ / __ / ____ | __ / __ / ____ |

## EPIDEMIOLOGIC EXPOSURES (based on the above exposure period, unless otherwise specified)

Y N U

☐ ☐ ☐ History of travel during exposure period (if yes, complete travel history below):

| Destination (City, County, State and Country) | Arrival Date | Departure Date | Reason for travel |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Y N U

☐ ☐ ☐ Artificial water-holding containers present near residence
☐ ☐ ☐ Areas of standing water present near residence
☐ ☐ ☐ Hardwood forest present near residence
☐ ☐ ☐ Poorly draining gutters present near residence
☐ ☐ ☐ Window/door screens in disrepair or missing at residence

***Geographic coordinates of patient residence:**
**Latitude: _____ Longitude: _____**
(Indicate units:
☐Decimal Degrees ☐Degrees Minutes Seconds ☐Other)

Y N U

☐ ☐ ☐ Blood transfusion 30 days prior to onset (Date:__/__/____ )
☐ ☐ ☐ Organ transplant 30 days prior to onset (Date:__/__/____ )
☐ ☐ ☐ Case was prenatally exposed (in utero)
☐ ☐ ☐ Case is a breast-fed infant
☐ ☐ ☐ Outdoor recreational activities (e.g. hiking, camping, etc)
☐ ☐ ☐ Mosquito bite
☐ ☐ ☐ Tick bite (if Powassan or other tickborne arbovirus)
☐ ☐ ☐ Possible occupational exposure
☐ Laboratory worker (Date of exposure:__/__/____)
☐ Other occupation: _____

Where did exposure most likely occur? **County:** _____ **State:**_____ **Country:** _____

## PUBLIC HEALTH ISSUES

Y N U

☐ ☐ ☐ Case identified through blood donor screening
☐ ☐ ☐ Case donated blood products, organs or tissue in the 30 days prior to symptom onset
Date:__/__/____
Agency/location:_____
Type of donation:_____
☐ ☐ ☐ Case is pregnant (Due date: __/__/____)
☐ ☐ ☐ Case knows someone who had shared exposure and is currently having similar symptoms
☐ ☐ ☐ Epi link to another confirmed case of same condition
☐ ☐ ☐ Case is part of an outbreak
☐ ☐ ☐ Other:

## PUBLIC HEALTH ACTIONS

Y N U

☐ ☐ ☐ Notify blood or tissue bank or other facility where organs donated
☐ ☐ ☐ Notify patient obstetrician
☐ ☐ ☐ Disease education and prevention information provided to patient and/or family/guardian
☐ ☐ ☐ Recommended environmental measures to patient/family to reduce risk around home
☐ ☐ ☐ Education or outreach provided to employer
☐ ☐ ☐ Facilitate laboratory testing of other symptomatic persons who have a shared exposure
☐ ☐ ☐ Patient is lost to follow-up
☐ ☐ ☐ Other:

## WVEDSS

Y N U

☐ ☐ ☐ Entered into WVEDSS (**Entry date**: __ / __ / ____) **Case Status:** ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Unknown

## NOTES

*Incubation Periods:

**EEE**= 4-10 days **LAC**= 5-15 days **POW**= 7-28 days **WEE**= 5-15 days **WNV**= 2-14 days **SLE**= 5-15 days **CHIK**= 3-7 days